the fiscal year ending in the previous calendar year. The state or its designee uses the latest available ~~Medicare~~ Medicaid cost report in the absence of the Medicare cost report submitted in the fiscal year ending in the previous calendar year. To determine the cost-to-charge ratio (inpatient and outpatient) for each hospital, the state or its designee uses the total cost from Worksheet B, Part I, Column 25 and total charges from Worksheet C Part I, Column 6. The ratio is the total cost divided by the total gross patient charges. *

(2) The state or its designee determines the cost of services to patients who have no health insurance or source of third party payments for services provided during the fiscal year for each hospital. Hospitals are surveyed each year to determine charges that can be attributed to patients without insurance or other third party resources. The charges from reporting hospitals are multiplied by each hospital's cost-to-charge ratio (inpatient and outpatient) to determine the cost.

Hospitals that do not respond to the survey, or that are unable to determine accurately the charges attributed to patients without insurance, shall have their bad debt charges as defined in (b)(16), and their charity charges as defined in (b)(20), reduced by a percentage derived from a representative sample of hospitals to be determined annually by the state or its designee. The state derives the percentages using the following formula; for each specific category of hospitals listed in (g)(2)(A), the state sums the total amount of charges for patients without health insurance or other third party payments. For each specific category of hospitals listed in (g)(2)(A), the state sums the charity and bad debt charges. For each specific category of hospitals listed in (g)(2)(A), the state then divides the charges for patients without health insurance or other third party payments by the sum of charity and bad debt charges. The state then uses the resulting ratio for each specific category of hospitals listed in (g)(2)(A) in the following manner. Individual hospitals that do not respond to the survey, or that are unable to accurately determine the charges attributed to patients without insurance have their hospital's individual sum of bad debt and charity charges multiplied by the appropriate ratio for the specific hospital category. After the state has calculated a value for the charges for patients without health insurance or other source of third party payment for each individual hospital, the state multiplies each hospital's calculated value by that hospital's cost-to-charge ratio (inpatient and outpatient) to obtain the proxy cost of services delivered to uninsured patients at each hospital.

(A) The representative sample of hospitals is one of the following specific categories of hospitals: urban public, other urban, rural, state operated psychiatric and non-state psychiatric. In the event that less than 20 percent of the hospitals in a specific category provide data to the department, the state or its designee uses the overall ratio calculated for all responding hospitals. The state or its designee creates additional categories, by submitting a state plan amendment, as it deems appropriate for the economic and efficient operation of the Medicaid disproportionate share hospital program.

(B) After the state or its designee determines each disproportionate share hospital's cost of services to patients who have no health insurance or source of third

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party payments for services provided during the year, the state subtracts from each hospital's cost of services the amount of payments made by or on behalf of those patients who have no health insurance or source of third party payments for services provided during the year.

(h) The state or its designee trends each hospital's "hospital specific limit" calculated from its historical base period cost report from (g) of this state plan to the state's fiscal year disproportionate share program. For hospitals without full 12-month fiscal year cost reports, the state or its designee annualizes the cost to calculate the hospital specific limit. The state or its designee uses the inflation update factor, as defined in (b)(17), in calculating the adjusted hospital specific limit. The state or its designee calculates the number of months from the mid-point of the hospital's cost reporting period to the mid-point of the state fiscal year disproportionate share program. The state or its designee then multiplies the portion of the hospital's cost report year occurring in the state fiscal year by the inflation update factor used for each state fiscal year in the calculation of hospital reimbursement rates for each state fiscal year. The product of these calculations is multiplied by each hospital's hospital specific limit to obtain each hospital's adjusted hospital specific limit.

(i) The state or its designee compares the projected payment for each disproportionate share hospital, as determined by (e) and (f), with its adjusted hospital specific limit, as determined by (g) and (h). If the hospital's projected payment is greater than its adjusted hospital specific limit, the state or its designee reduces the hospital's payment to its adjusted hospital specific limit.

(j) If there are disproportionate share hospital funds left in the available fund for the remaining hospitals, because some hospitals have had their disproportionate share hospital payments reduced to their adjusted hospital specific limits, the state distributes the excess funds according to the provisions in this section. For hospitals whose projected disproportionate share hospital payments are less than their adjusted hospital specific limits, the state or its designee does the following:

(1) calculate the difference between its adjusted hospital specific limit and its projected disproportionate share hospital payment;
(2) add all of the differences from (j)(1);
(3) calculate a ratio for each hospital by dividing the difference from (j)(1) by the sum for (j)(2); and
(4) multiply the ratio from (j)(3) by the remaining available fund.

$$\text{Remaining Available} * \frac{\text{Hospital's Adjusted Limit - Hospital's Projected Disproportionate Share Payment}}{\text{Total}})$$

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Only those hospitals that are below their adjusted hospital specific limits are eligible to participate in this distribution. The disproportionate share hospital funds remaining in the available fund are distributed to the hospitals that have not already reached their adjusted hospital specific limits. Each hospital's total disproportionate share payment (including the redistribution of excess funds) cannot exceed its adjusted hospital specific limit.

(a) Effective December 12, 1990, a hospital owned and operated by a state university or other agency of the state is eligible for disproportionate share reimbursement. A state-owned teaching hospital is a hospital owned and operated by a state university or other agency of the state.

(b) Each hospital must have a Medicaid inpatient utilization rate as defined in §1923(b)(2), at a minimum, of one percent in accordance with §§1923(d)(3) and 1923(e)(2)(C) of the Social Security Act.

(c) To qualify for disproportionate share payments, each hospital must have at least two physicians (M.D. or D.O.), with staff privileges at the hospital, who have agreed to provide nonemergency obstetrical services to Medicaid clients. The two-physician requirement does not apply to hospitals whose inpatients are predominantly under 18 years old or that did not offer nonemergency obstetrical services to the general population as of December 22, 1987.

(d) For purposes of this state plan:

(1) Total Medicaid inpatient days means the total number of Title XIX inpatient days based on the latest available state fiscal year data for patients eligible for Title XIX benefits. The term excludes days for patients who are covered for services which are fully or partially reimbursable by Medicare. The term includes Medicaid-eligible days of care billed to managed care organizations. Total Medicaid inpatient days includes days that were denied payment for reasons other than eligibility. Included are inpatient days of care provided to patients eligible for Medicaid at the time the service was provided, regardless of whether the claim was filed or paid. Examples of these denied claims include, but are not limited to, claims for patients whose spell of illness limits are exhausted, or claims that were filed late. The term excludes days attributable to Medicaid patients between the ages of 21 and 65 who live in an institution for mental diseases. The term includes days attributable to individuals eligible for Medicaid in other states.

(2) Total inpatient census days means the total number of a hospital's inpatient census days during its fiscal year ending in the previous calendar year.

(3) Cost of services to uninsured patients are the inpatient and outpatient charges to patients who have no health insurance or other source of third party payment for services provided during the year, multiplied by the hospital's ratio of costs to charges (inpatient and outpatient), less the amount of payments made by or on behalf of those

patients. Uninsured patients are patients who have no health insurance or other source of third party payments for services provided during the year. Uninsured patients include those patients who do not possess health insurance that would apply to the service for which the individual sought treatment. Cost of services does not include any bad debt charges.

(4) Hospital specific limit is the sum of the following two measurements: (a) Medicaid shortfall; and (b) cost of services to uninsured patients.

(5) Medicaid shortfall is the cost of services (inpatient and outpatient) furnished to Medicaid patients, less the amount paid under the nondisproportionate share hospital payment method under this state plan.

(6) Cost-to-charge ratio (inpatient and outpatient) is the hospital's overall cost-to-charge ratio, as determined from its ~~Medicare~~ Medicaid cost report submitted for the fiscal year ending in the previous calendar year. The latest available Medicare cost report is used in the absence of the cost report for the hospital's fiscal year ending in the previous calendar year. *

(7) Adjusted hospital specific limit is a hospital specific limit trended forward to account for the inflation update factor since the base year.

(8) Inflation update factor is a general increase in prices as determined by the state. For additional information concerning the inflation update factor, see §(n)(2), page 8 of the Methods and Standards for Establishing Payment Rates--Inpatient Services, of this state plan.

(9) Medicaid inpatient utilization rate is the rate defined in §1923(b)(2) of the Social Security Act.

(10) Payments received from uninsured patients are those payments received from or on behalf of uninsured patients as defined in (d)(3).

(11) Charity charges are the total amount of hospital charges for inpatient and outpatient services attributed to charity care in a cost reporting period, as reported on the state teaching hospitals' annual financial reports, for use only in the calculation of the disproportionate share hospital payment under section 1923(e).

(12) Allowable cost is defined by the state using the same methods and procedures that are reflected in both the inpatient and outpatient sections of the currently approved state plan.

(13) Available fund for state teaching hospitals is the total amount of funds that may be reimbursed to the state teaching hospitals as determined below.

(e) The single state agency reimburses state-owned teaching hospitals on a monthly basis from the available fund for state teaching hospitals. Monthly payments equal one-twelfth of annual payments unless it is necessary to adjust the amount because payments are not made for a full 12-month period, to comply with the annual state disproportionate share hospital allotment, or to comply with other state or federal disproportionate share hospital program requirements.

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Prior to the start of the next federal fiscal year, the single state agency determines the size of the fund to reimburse state-owned teaching hospitals for the next federal fiscal year. The available fund to reimburse the state teaching hospitals equals the total of their disproportionate share hospital payments, as determined below:

(1) A state teaching hospital will receive a monthly disproportionate share payment based on the following formula:

$$\frac{\text{Monthly Charity Charges of the State-Owned Teaching Hospital}}{\text{Total Monthly Charity Charges of All State-Owned Teaching Hospitals}} \times \text{Available Fund}$$

(2) Under the requirements of section 1923(g), if the adjusted hospital specific limit for a state teaching hospital is less than the formula above, a state teaching hospital will receive 100 percent of its adjusted hospital specific limit, instead of the amount determined under (1) above.

(f) The state or its designee determines the hospital specific limit for each disproportionate share hospital. This limit is the sum of a hospital's Medicaid shortfall, as defined in (d)(5), and its cost of services to uninsured patients as defined in (d)(3), multiplied by the appropriate inflation update factor, as provided for in (g).

(1) The Medicaid shortfall includes total Medicaid billed charges and any Medicaid payments made for the corresponding inpatient and outpatient services delivered to Texas Medicaid clients, as determined from the hospital's fiscal year claims data, regardless of whether the claim was paid. Examples of these denied claims include, but are not limited to, patients whose spell of illness claims were exhausted, or payments were denied due to late filing. (See definition of "Medicaid shortfall.)

The total billed Medicaid charges for each hospital are converted to cost, utilizing a calculated cost-to-charge ratio (inpatient and outpatient). The state or its designee determines that ratio by using the hospital's ~~Medicare~~ Medicaid cost report that was submitted for the fiscal year ending in the previous calendar year. The state or its designee uses the latest available ~~Medicare~~ Medicaid cost report in the absence of the ~~Medicare~~ Medicaid cost report submitted in the fiscal year ending in the previous calendar year. To determine the cost-to-charge ratio (inpatient and outpatient) for each hospital, the state or its designee uses the total cost from Worksheet B, Part 1, Column 25 and total charges from Worksheet C, Part 1, Column 6. The ratio is the total cost divided by the total gross patient charges. *

(2) The state or its designee determines the cost of services to patients who have no health insurance or source of third party payments for services provided during the year for each hospital. Hospitals are surveyed each year to determine charges that can be attributed to patients without insurance or other third party resources. The charges are multiplied by each hospital's cost-to-charge ratio (inpatient and outpatient) to determine

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the cost.

After the state or its designee determines each disproportionate share hospital's cost of services to patients who have no health insurance or source of third party payments for services provided during the year, the state subtracts from each hospital's cost of services the amount of payments made by or on behalf of those patients who have no health insurance or source of third party payments for services provided during the year.

(g) The state or its designee trends each hospital's "hospital specific limit" calculated from its historical base period cost report from (f) of this state plan to the state's fiscal year disproportionate share program. For hospitals without full 12-month fiscal year cost reports, the state or its designee annualizes the cost to calculate the hospital specific limit. The state or its designee uses the inflation update factor, as defined in (d)(8), in calculating the adjusted hospital specific limit. The state or its designee calculates the number of months from the mid-point of the hospital's cost reporting period to the mid-point of the state fiscal year disproportionate share program. The state or its designee then multiplies the portion of the hospital's cost report year occurring in the state fiscal year by the inflation update factor used for each state fiscal year in the calculation of hospital reimbursement rates for each state fiscal year. The product of these calculations is multiplied by each hospital's hospital specific limit to obtain each hospital's adjusted hospital specific limit.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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October 31, 2001

Our reference: SPA-TX-01-10

Ms. Linda K. Wertz, State Medicaid Director
Texas Health and Human Services Commission
Post Office Box 13247
Austin, TX 78711

Dear Ms. Wertz:

We have reviewed the proposed amendment to your Medicaid State plan submitted under transmittal no. (TN) 01-10, including the pen and ink changes requested on October 2, 2001. Effective September 1, 2001, this amendment establishes an additional criterion that hospitals may use to qualify for disproportionate share hospital (DSH) payments. Hospitals with at least 75% of one standard deviation above the mean Medicaid inpatient days for all hospitals and located in urban counties with populations of 250,000 or less will qualify for DSH payments.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13)(A), 1902(a)(30), and 1923 of the Social Security Act and the implementing federal regulations at 42 CFR 447 Subpart C. We have approved the amendment for incorporation into the official Texas State plan effective on September 1, 2001. We have enclosed a copy of HCFA-179, transmittal no. 01-10, dated October 31, 2001, and the amended plan pages.

If you have any questions, please call Billy Bob Farrell at (214) 767-6449.

Sincerely,

Calvin G. Cline

Calvin G. Cline
Associate Regional Administrator
Division of Medicaid and State Operations

Enclosures

cc: Elliot Weisman, CMSO, PCPG
Commerce Clearing House

CMS
CENTERS for MEDICARE & MEDICAID SERVICES